SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
Company Tracking Number:	*GH AR0185701F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2009 Student Health	SERFF Tr Num: AENX-126181534	State: ArkansasLH
TOI: H04 Health - Blanket Accident/Sickness	SERFF Status: Closed	State Tr Num: 42590
Sub-TOI: H04.001 Student	Co Tr Num: GH AR0185701F01	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: SPI AetnaSPI	Disposition Date: 06/09/2009
	Date Submitted: 06/08/2009	Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2009 Student Health	Status of Filing in Domicile:
Project Number: GH AR0185701F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 06/09/2009	Explanation for Other Group Market Type:
	State Status Changed: 06/09/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

The purpose of this filing is to support the following options for our dental products:

1. Addition of coverage for vertical bitewing x-rays, core build-up, implants, adjunctive pre-diagnostic tests, brush biopsy, full mouth debridement, and bone grafts services.

2. Addition of two new dental exclusions: "replacement of teeth beyond the normal complement of 32" and "other than for covered preventive services, services and supplies provided where there is no evidence of pathology, dysfunction, or

disease."

Company and Contact

Filing Contact Information

John Ciesielski, Product and Regulatory Affairs Manager
151 Farmington Avenue
Hartford, CT 06156

CiesielskiJW@Aetna.com
(860) 279-1282 [Phone]
(860) 952-2069[FAX]

Filing Company Information

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-7546 ext. [Phone]

CoCode: 60054
Group Code: 1
Group Name: Aetna
FEIN Number: 06-6033492

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	$0.00	06/08/2009	

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/09/2009	06/09/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
filing fee check	Supporting Document	SPI AetnaSPI	06/09/2009	06/09/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
FILING FEE	Note To Filer	Rosalind Minor	06/09/2009	06/09/2009

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
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Company Tracking Number:	*GH AR0185701F01*		
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Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Disposition

Disposition Date: 06/09/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
Company Tracking Number:	*GH AR0185701F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Attachment A, EOV AL GE ASTUD03100E V002, EOV AL GE ASTUD03105E V002, EOV AL GE ASTUD03110E V002, EOV AL GE ASTUD03115E V002, EOV AL GE ASTUD3120-1E V002, EOV AL GE ASTUD3120-2E V002, EOV AL GE ASTUD03135E V002, EOV AL GE ASTUD03140E V002, EOV AL GE, ...	Approved-Closed	Yes
Supporting Document	filing fee check	Approved-Closed	Yes
Form	Dental PPO - Type A & B Visits and X-Rays	Approved-Closed	Yes
Form	Dental PPO - Type B - Oral Surgery, Periodontics, Endodontics	Approved-Closed	Yes
Form	Dental PPO - Type B continued, Type C	Approved-Closed	Yes
Form	Dental PPO - Type C - Restorative, Prosthodontics	Approved-Closed	Yes
Form	Dental PPO - Type C continued	Approved-Closed	Yes
Form	Dental PPO - Type C continued	Approved-Closed	Yes
Form	Comprehensive Dental - Plan Features	Approved-Closed	Yes
Form	Comprehensive Dental - Plan Coinsurance	Approved-Closed	Yes
Form	Comprehensive Dental - Type A & B Visits and X-Rays	Approved-Closed	Yes
Form	Comprehensive Dental - Type B - Oral Surgery, Periodontics, Endodontics	Approved-Closed	Yes
Form	Comprehensive Dental - Type B Continued. Type C	Approved-Closed	Yes
Form	Comprehensive Dental - Type C - Restorative, Prosthodontics	Approved-Closed	Yes
Form	Comprehensive Dental - Type C continued	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
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Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Form	Comprehensive Dental - Type C continued	Approved-Closed	Yes
Form	Exclusions That Apply To The Dental Plan	Approved-Closed	Yes

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
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Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Amendment Letter

Amendment Date:

Submitted Date: 06/09/2009

Comments:

Attached is copy of check for filing fee.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: filing fee check

Comment: check # 522850

filing fee check.PDF

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
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Note To Filer

Created By:
Rosalind Minor on 06/09/2009 09:51 AM
Last Edited By:
Rosalind Minor
Submitted On:
06/09/2009 01:56 PM
Subject:
FILING FEE
Comments:

Please submit a filing fee in the amount of $20.00 for this submission.

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
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TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Form Schedule

Lead Form Number: GR-96134 3100 Ed. 05/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GR-96134 3100 Ed. 05/09	Schedule Pages	Dental PPO - Type A & B Visits and X-Rays	Initial		0	GR-96134 3100 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3105 Ed. 05/09	Schedule Pages	Dental PPO - Type B - Oral Surgery, Periodontics, Endodontics	Initial		0	GR-96134 3105 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3110 Ed. 05/09	Schedule Pages	Dental PPO - Type B continued, Type C	Initial		0	GR-96134 3110 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3115 Ed. 05/09	Schedule Pages	Dental PPO - Type C - Restorative, Prosthodontics	Initial		0	GR-96134 3115 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3120-1 Ed. 05/09	Schedule Pages	Dental PPO - Type C continued	Initial		0	GR-96134 3120-1 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3120-2 Ed. 05/09	Schedule Pages	Dental PPO - Type C continued	Initial		0	GR-96134 3120-2 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3135 Ed. 05/09	Schedule Pages	Comprehensive Dental - Plan Features	Initial		0	GR-96134 3135 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3140 Ed. 05/09	Schedule Pages	Comprehensive Dental - Plan Coinsurance	Initial		0	GR-96134 3140 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3155 Ed. 05/09	Schedule Pages	Comprehensive Dental - Type A & B Visits and X-Rays	Initial		0	GR-96134 3155 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3160 Ed. 05/09	Schedule Pages	Comprehensive Dental - Type B - Oral Surgery, Periodontics,	Initial		0	GR-96134 3160 Ed_ 05_09.PDF

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
Company Tracking Number:	*GH AR0185701F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

			Endodontics				
Approved-Closed	GR-96134 3165 Ed. 05/09	Schedule Pages	Comprehensive Dental - Type B Continued. Type C	Initial	0	GR-96134 3165 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3170 Ed. 05/09	Schedule Pages	Comprehensive Dental - Type C - Restorative, Prosthodontics	Initial	0	GR-96134 3170 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3175-1 Ed. 05/09	Schedule Pages	Comprehensive Dental - Type C continued	Initial	0	GR-96134 3175-1 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3175-2 Ed. 05/09	Schedule Pages	Comprehensive Dental - Type C continued	Initial	0	GR-96134 3175-2 Ed_ 05_09.PDF
Approved-Closed	GR-96134 3185 Ed. 05/09	Certificate	Exclusions That Apply To The Dental Plan	Initial	0	GR-96134 3185 Ed_ 05_09.PDF

[PPO DENTAL CARE SCHEDULE]

Unless otherwise specified below, all per year maximum limit references apply on a Policy Year basis.

[Type A Expenses: Diagnostic and Preventive Care

VISITS AND X-RAYS
Office visit during regular office hours. For oral examination. Limited to 2-6 visits every year.
Prophylaxis (cleaning). Limited to 2-6 treatments per year.
Topical application of fluoride. Limited to 1-4 courses of treatment per year and to covered persons under age 14-30.
Sealants - per tooth. Limited to 1-2 applications every 1-5 years for permanent bicuspids and molars only - to covered persons under age 14-30.
Bitewing X-rays Limited to 1-4 set per year.
Entire dental series - , including bitewings or panoramic film limited to 1-8 sets every 1-5 years.
Vertical bitewing X-rays. Limited to 1-4 sets every 1-5 years.

[Type B Expenses: Basic Restorative Care

VISITS AND X-RAYS
Professional visit after hours. Payment will be made on the basis of services rendered or visit, whichever is greater.
Emergency palliative treatment - per visit.

X-RAY AND PATHOLOGY
Periapical x-rays - single films up to 13-25 films.
Intra-oral - occlusal view - maxillary or mandibular.
Upper or lower jaw - extra-oral.
Biopsy and histopathologic examination of oral tissue.

[Type B Expenses: Basic Restorative Care (continued)

ORAL SURGERY
Extractions
Exposed root or erupted tooth
Surgical removal of erupted tooth
Impacted Teeth
    Removal of tooth (soft tissue)
Odontogenic Cysts and Neoplasms
    Incision and drainage of abscess
    Removal of odontogenic cyst or tumor
Other Surgical Procedures
    Alveoplasty, in conjunction with extractions - per quadrant
    Alveoplasty, not in conjunction with extraction - per quadrant
    Sialolithotomy, removal of salivary calculus
    Closure of salivary fistula
    Excision of hyperplastic tissue
    Removal of exostosis
    Transplantation of tooth or tooth bud
    Closure of oral fistula of maxillary sinus
    Sequestrectomy
    Crown exposure to aid eruption
    Removal of foreign body from soft tissue
    Frenectomy
    Suture of soft tissue injury

PERIODONTICS
Occlusal adjustment. Other than with an appliance or by restoration.
Root planning and scaling, per quadrant. Limited to 1-4 separate quadrants every 1-2 years.
Root planning and scaling. 1 to 3 teeth per quadrant (limited to 1-4 per site every 1-2 years.
Gingivectomy, per quadrant. Limited to 1-2 per quadrant every 1-3 years.
Gingivectomy 1 to 3 teeth per quadrant. Limited to 1-2 per site every 1-3 years.
Gingival flap procedure. Per quadrant, limited to 1-2 per quadrant every 1-3 years.
Gingival flap procedure. 1 to 3 teeth per quadrant (limited to 1-2 per site every 1-3 years.
Periodontal maintenance procedures following active therapy (limited to 1-2 per year).
Localized delivery of chemotherapeutic agents.

ENDODONTICS
Pulp cap
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy including necessary X-rays
    Anterior
    Bicuspid]

[PPO DENTAL EXPENSE BENEFITS (Continued)]

[PPO DENTAL CARE SCHEDULE]

[Type B Expenses: Basic Restorative Care (continued)

RESTORATIVE DENTISTRY Excludes inlays. Crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
Amalgam restorations
Resin-based composite restorations (other than for molars)
Pins
Pin retention—per tooth; in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material)
Prefabricated stainless steel
Prefabricated resin crown (excluding temporary crowns)
Recementation
- Inlay
- Crown
- Bridge]

[Type C Expenses: Major Restorative Care

ORAL SURGERY
Impacted Teeth
- Removal of tooth (partially bony)
- Removal of tooth (completely bony)
- Brush biopsy

PERIODONTICS
Osseous surgery (including flap and closure). 1 to 3 teeth per quadrant, limited to 1-4 per quadrant, every 1-5 years.
Osseous surgery (including flap and closure). Per quadrant, limited to 1-4 per site, every 1-5 years.
Soft tissue graft procedures.
Clinical Crown Lengthening. Hard Tissue.
Full mouth debridement. Limited to 1-4 per lifetime.
Bone grafts. First site in quadrant . Limited to 1-4 per lifetime.
Bone grafts. Each additional site in quadrant limited to 1-4 per lifetime.

ENDODONTICS
Root canal therapy, including necessary X-rays
Molar]

[PPO DENTAL EXPENSE BENEFITS (Continued)]

[PPO DENTAL CARE SCHEDULE
[Type C Expenses: Major Restorative Care (continued)

RESTORATIVE -- [Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Limited to 1-2 per tooth every 1-10 years. (See *Replacement Rule.*)

Inlays/Onlays-Metallic or Porcelain/Ceramic
- Inlay- 1 or more surfaces
- Onlay- 2 or more surfaces

Inlays/Onlays - Resin-based composite
- Inlay- 1 or more surfaces
- Onlay- 2 or more surfaces]

Labial Veneers
- Laminate - chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns
Resin with noble or base metal

Porcelain with noble or base metal

Base metal (full cast)
Noble metal (full cast)
Metallic (3/4 cast)
Post and core
Core Build-Up

PROSTHODONTICS - First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 1-10 years old. (See *Tooth Missing But Not Replaced Rule.*) Replacement of existing bridges or dentures is limited to 1 every 1-10 years. (See *Replacement Rule.*)

Bridge Abutments (See Inlays and Crowns)
Pontics
- Base metal (full cast)
- Noble metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal]

[PPO DENTAL EXPENSE BENEFITS (Continued)]

[PPO DENTAL CARE SCHEDULE]

[Type C Expenses: Major Restorative Care (continued)

PROSTHODONTICS (CONTINUED)
Removable Bridge (unilateral)
One piece casting; chrome cobalt alloy clasp attachment (all types) per unit; including pontics
Dentures and Partials (Fees for dentures and partial dentures include
relines; rebases; and adjustments; within 6 months after installation.
Fees for relines and rebases include adjustments within 6 months after
installation. Specialized techniques and characterizations are not eligible.)
Complete upper denture
Complete lower denture
Partial upper or lower; resin base (including any conventional clasps; rests and teeth)
Partial upper or lower; cast metal base with resin saddles (including any conventional clasps; rests and teeth) Stress breakers
Interim partial denture (stayplate); anterior only
Office reline
Laboratory reline
Special tissue conditioning
Rebase
Adjustment to denture more than 6 months after installation
Full and partial denture repairs
Broken dentures; no teeth involved
Repair cast framework
Replacing missing or broken teeth; each tooth
Adding teeth to existing partial denture: Teeth and clasps
Repairs: crowns and bridges
Occlusal guard (for bruxism only); limited to 1-4 every 1-5 years]

[IMPLANTS]

[SPACE MAINTAINERS -- Only when needed to preserve space resulting from premature loss of decidous teeth. (Includes all adjustments within 6 months after installation**.)**

Fixed (unilateral or bilateral)
Removable (unilateral or bilateral)
Removable inhibiting appliance to correct thumbsucking
Fixed or cemented inhibiting appliance to correct thumbsucking]

[GENERAL ANESTHESIA AND INTRAVENOUS SEDATION -- (Only when provided in conjunction with a covered procedure)]

[PPO DENTAL EXPENSE BENEFITS (Continued)]

[PPO DENTAL CARE SCHEDULE]

[Type C Expenses: Major Restorative Care (continued)

[ORTHODONTICS
Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of dentition
Post treatment stabilization]]

[VISITS AND EXAMS
Adjunctive pre-diagnostic tests (limited to 2-6 visits every year)]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

[The plan pays a benefit up to the Dental Emergency Maximum shown in the Dental Care Schedule].

The care provided must be a covered service or supply. A **covered person** must submit a claim to **Aetna** describing the care given. [Follow-up care is not considered an emergency condition and is not covered as part of any emergency care visit. Once you have been treated and discharged, you should contact your **dentist** for any necessary follow-up care. For coverage purposes, follow-up care is treated as any other **covered dental expense** for routine **illness** or **injury**.]

[COMPREHENSIVE] [LIMITED] DENTAL CARE SCHEDULE

PLAN FEATURES

[Policy Year Deductible
Individual $[25-200]
Family $[50-600]

[The policy year **deductible** applies to all **covered expenses** except Type A Expenses.]

[**Covered expenses** that are subject to the **deductible** include Medical, **Prescription Drug**, Dental, Vision; and Hearing expenses provided under the **Aetna** [Medical], [**Prescription Drug**], [Dental], [Vision], [Hearing] plan.].

[Orthodontic Deductible
The orthodontic **deductible** applies separately to **covered students** and their **covered dependents**. After **covered dental expenses** reach the orthodontic **deductible**, the plan will begin to pay benefits for covered orthodontic expenses for the rest of the policy year.]

Orthodontic **Deductible:** $[25-1,000]]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

[COMPREHENSIVE] [LIMITED] DENTAL CARE SCHEDULE
[PLAN COINSURANCE

[The percentage the plan will pay varies by the type of expense.]

[**Type A Expenses**	[100 - 70]%]
[Type B Expenses	[100 - 30]%;]
[Type C Expenses	[100 - 30]%;]
[Orthodontic Treatment	[100 - 30]%]
[Plan Coinsurance Limit (per policy year)	$[10,000] Individual $[30,000] Family]

For certain **covered dental expenses**, the amount the **covered person** is required to pay is limited. In addition to the Policy Year C**oinsurance Limit**, which applies separately to the **covered person**, there is also a family limit.

Certain **covered dental expenses** do not apply toward the Individual Policy Year **Coinsurance Limit** and the Family Policy Year **Coinsurance Limit**. These include:

- Expenses applied toward a **deductible** or **copay** amount.
- Expenses above the **recognized** [**charge]**.]

[Policy Year Maximum Benefit

Policy Year Maximum Benefit: $[500-10,000]

The most the plan will pay for **covered dental expenses** incurred by any one **covered person** in a policy year is called the Policy Year Maximum Benefit.

[**Covered expenses** that are subject to the **deductible** include Medical, **Prescription Drug**, Dental, Vision; and Hearing expenses provided under the **Aetna** [Medical], [**Prescription Drug**], [Dental], [Vision], [Hearing] plan.].]]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

[COMPREHENSIVE] [LIMITED] DENTAL CARE SCHEDULE
Unless otherwise specified below, all per year maximum limit references apply on a Policy Year basis.

[[Type A Expenses: Diagnostic and Preventive Care]

VISITS AND X-RAYS
Office visit during regular office hours for oral examination (limited to 2-6 visits every year).
Prophylaxis (cleaning) (limited to 2-6 treatments per year).
Topical application of fluoride (limited to 1-4 courses of treatment per year and to covered persons under age 14-30).
Sealants per tooth (limited to 1-2 application every 1-5 years for permanent bicuspids and molars only and to covered persons under age 14-30).
Bitewing X-rays (limited to 1-4 set per year).
Entire dental series including bitewings or panoramic film (limited to 1-8 sets every 1-5 years)].
Vertical bitewing X-rays (limited to 1-4 sets every 1-5 years).

[Type B Expenses: Basic Restorative Care

VISITS AND X-RAYS
Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater).
Emergency palliative treatment per visit.

X-RAY AND PATHOLOGY
Periapical x-rays (single films up to 13-25 films).
Intra-oral occlusal view maxillary or mandibular.
Upper or lower jaw extra-oral.
Biopsy and histopathologic examination of oral tissue,]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

[COMPREHENSIVE] [LIMITED] DENTAL CARE SCHEDULE
[[Type B Expenses: Basic Restorative Care (continued)]

ORAL SURGERY
Extractions
Exposed root or erupted tooth
Surgical removal of erupted tooth
Impacted Teeth
    Removal of tooth (soft tissue)
Odontogenic Cysts and Neoplasms
    Incision and drainage of abscess
    Removal of odontogenic cyst or tumor
Other Surgical Procedures
    Alveoplasty; in conjunction with extractions
    Alveoplasty; not in conjunction with extraction
    Sialolithotomy: removal of salivary calculus
    Closure of salivary fistula
    Excision of hyperplastic tissue
    Removal of exostosis
    Transplantation of tooth or tooth bud
    Closure of oral fistula of maxillary sinus
    Sequestrectomy
    Crown exposure to aid eruption
    Removal of foreign body from soft tissue
    Frenectomy
    Suture of soft tissue injury

PERIODONTICS
Occlusal adjustment (other than with an appliance or by restoration).
Root planning and scaling per quadrant. Limited to 1-4 separate quadrants every 1-2 years.
Root planning and scaling – 1 to 3 teeth per quadrant. Limited to 1-4 per site every 1-2 years.
Gingivectomy per quadrant. Limited to 1-2 per quadrant every 1-3 years.
Gingivectomy 1 to 3 teeth per quadrant. Limited to 1-2 per site every 1-3 years.
Gingival flap procedure - per quadrant. Limited to 1-2 per quadrant every 1-3 years.
Gingival flap procedure – 1 to 3 teeth per quadrant. Limited to 1-2 per site every 1-3 years.
Periodontal maintenance procedures following active therapy. Limited to 1-2 per year.
Localized delivery of chemotherapeutic agents.

ENDODONTICS
Pulp cap
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy including necessary X-rays
    Anterior
    Bicuspid]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

[COMPREHENSIVE] [LIMITED] DENTAL CARE SCHEDULE
[[Type B Expenses: Basic Restorative Care (continued)]

RESTORATIVE DENTISTRY Excludes inlays crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
Amalgam restorations
Resin-based composite restorations (other than for molars)
Pins
Pin retention - in addition to amalgam or resin restoration
Crowns (when tooth cannot be restored with a filling material)
Prefabricated stainless steel
Prefabricated resin crown (excluding temporary crowns)
Recementation
- Inlay
- Crown
- Bridge]

[Type C Expenses: Major Restorative Care

ORAL SURGERY
Impacted Teeth
- Removal of tooth (partially bony)
- Removal of tooth (completely bony)
- Brush biopsy

PERIODONTICS
Osseous surgery (including flap and closure). 1 to 3 teeth per quadrant. Limited to 1-4 per quadrant every 1-5 years.
Osseous surgery (including flap and closure) per quadrant. Limited to 1-4 per site every 1-5 years.
Soft tissue graft procedures
Clinical Crown Lengthening – Hard Tissue.

Full mouth debridement limited to 1-4 per lifetime.
Bone grafts first site in quadrant. Limited to 1-4 per lifetime.
Bone grafts each additional site in quadrant. Limited to 1-4 per lifetime.

ENDODONTICS
Root canal therapy, including necessary X-rays.
Molar]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

COMPREHENSIVE [LIMITED] DENTAL CARE SCHEDULE
[[Type C Expenses: Major Restorative Care (continued)

RESTORATIVE [Inlays, onlays, labial veneers and crowns are **covered dental expenses** only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1-2 per tooth every 1-10 years) – (See *Replacement Rule*)

Inlays/Onlays-Metallic or Porcelain/Ceramic
- Inlay 1 or more surfaces
- Onlay 2 or more surfaces

Inlays/Onlays-Resin-based composite
- Inlay 1 or more surfaces
- Onlay 2 or more surfaces]

[Labial Veneers
- Laminate-chairside
- Resin laminate – laboratory
- Porcelain laminate – laboratory

Crowns
Resin with noble or base metal

Porcelain with noble or base metal

Base metal (full cast)
Noble metal (full cast)
Metallic (3/4 cast)
Post and core
Core Build-Up

PROSTHODONTICS- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 1-10 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 1-10 years. (See *Replacement Rule*.)

Bridge Abutments (See Inlays and Crowns)
Pontics
- Base metal (full cast)
- Noble metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

COMPREHENSIVE [LIMITED] DENTAL CARE SCHEDULE
[[Type C Expenses: Major Restorative Care (continued)]

PROSTHODONTICS (continued)
Removable Bridge (unilateral)
One piece casting chrome cobalt alloy clasp attachment (all types) per unit including pontics].
Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation.
Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)

- Complete upper denture
- Complete lower denture
- Partial upper or lower resin base (including any conventional clasps rests and teeth)
- Partial upper or lower cast metal base with resin saddles (including any conventional clasps rests and teeth)]

Stress breakers
Interim partial denture (stayplate), anterior only
Office reline

- Laboratory reline
- Special tissue conditioning per denture
- Rebase per denture
- Adjustment to denture more than 6 months after installation

Full and partial denture repairs
Broken dentures no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth
Adding teeth to existing partial denture. Teeth and clasps.

- Each tooth
- Each clasp

Repairs crowns and bridges
Occlusal guard (for bruxism only). Limited to 1-4 every 1-5 years.

[IMPLANTS]

[SPACE MAINTAINERS Only when needed to preserve space resulting from premature loss of decidous teeth. Includes all adjustments within 6 months after installation.

Fixed (unilateral or bilateral)
Removable (unilateral or bilateral)
Removable inhibiting appliance to correct thumbsucking
Fixed or cemented inhibiting appliance to correct thumbsucking]

[GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (only when provided in conjunction with a covered procedure)]

[STUDENT ACCIDENT AND SICKNESS INSURANCE]

[SECTION 6 - COVERAGE (Continued)]

[COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

COMPREHENSIVE [LIMITED] DENTAL CARE SCHEDULE
[[Type C Expenses: Major Restorative Care (continued)]

[ORTHODONTICS
Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of dentition
Post treatment stabilization]]

[VISITS AND EXAMS
Adjunctive pre-diagnostic tests (limited to 2-6 visits every year).]

[PPO] [COMPREHENSIVE] [LIMITED] DENTAL EXPENSE BENEFITS]

[EXCLUSIONS THAT APPLY TO THE DENTAL PLAN

[Except as covered in the Dental Care Schedule section, non-surgical and surgical treatment of any **jaw joint disorder** and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.]

[**Orthodontic treatment,** except as covered in the Dental Care Schedule].

Pontics crowns cast or processed restorations made with high noble metals (gold or titanium).

Prescribed drugs pre-medication or analgesia.

Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

[Replacement of teeth beyond the normal complement of 32.]

[Removal of soft bony impactions.]

[Other than for covered preventive services, services and supplies provided where there is no evidence of pathology, dysfunction, or disease.]

[Surgical removal of impacted wisdom teeth when only for orthodontic reasons.]

[Topical application of fluoride.]

[Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentis**t. These are:

- Scaling of teeth, and
- Cleaning of teeth.]

[Treatment of alveolectomy.]

[Treatment of periodontal disease.]]

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
Company Tracking Number:	*GH AR0185701F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
Company Tracking Number:	*GH AR0185701F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Application — Approved-Closed — 06/09/2009

Bypass Reason: not applicable

Comments:

Review Status:

Bypassed -Name: Flesch Certification — Approved-Closed — 06/09/2009

Bypass Reason: Forms include scheduled amounts. In addition forms included as part of complete certifcate exceed the minimum reading ease score,

Comments:

Review Status:

Satisfied -Name: Cover Letter — Approved-Closed — 06/09/2009

Comments:

Attachment:

Cover Letter.PDF

Review Status:

Satisfied -Name: Attachment A, EOV AL GE — Approved-Closed — 06/09/2009

ASTUD03100E V002, EOV AL GE
ASTUD03105E V002, EOV AL GE
ASTUD03110E V002, EOV AL GE
ASTUD03115E V002, EOV AL GE
ASTUD3120-1E V002, EOV AL GE
ASTUD3120-2E V002, EOV AL GE
ASTUD03135E V002, EOV AL GE
ASTUD03140E V002, EOV AL GE,
...

Comments:

Attachments:

Attachment A.PDF
EOV AL GE ASTUD03100E V002.PDF
EOV AL GE ASTUD03105E V002.PDF

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
Company Tracking Number:	*GH AR0185701F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

EOV AL GE ASTUD03110E V002.PDF
EOV AL GE ASTUD03115E V002.PDF
EOV AL GE ASTUD3120-1E V002.PDF
EOV AL GE ASTUD3120-2E V002.PDF
EOV AL GE ASTUD03135E V002.PDF
EOV AL GE ASTUD03140E V002.PDF
EOV AL GE ASTUD03155E V002.PDF
EOV AL GE ASTUD03160E V002.PDF
EOV AL GE ASTUD03165E V002.PDF
EOV AL GE ASTUD03170E V002.PDF
EOV AL GE ASTUD3175-1E V002.PDF
EOV AL GE ASTUD3175-2E V002.PDF
EOV AL GE ASTUD03185E V002.PDF

SERFF Tracking Number:	*AENX-126181534*	*State:*	*Arkansas*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*42590*
Company Tracking Number:	*GH AR0185701F01*		
TOI:	*H04 Health - Blanket Accident/Sickness*	*Sub-TOI:*	*H04.001 Student*
Product Name:	*2009 Student Health*		
Project Name/Number:	*2009 Student Health/GH AR0185701F01*		

Satisfied -Name: filing fee check

Review Status:
Approved-Closed 06/09/2009

Comments:
check # 522850

Attachment:
filing fee check.PDF

June 8, 2009

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Form Filing - 2009 SH- 2009 Student Health Dental Enhancements (ALIC)
Group Health
Company Filing#: GH AR0185701F01
Aetna Life Insurance Company NAIC#: 001-60054 FEIN#: 06-6033492
Lead Form No.: GR-96134 3100 Ed. 05/09 et al

Dear Commissioner Bradford:

We wish to submit the following Form filing for Group, Group Health for use in Arkansas.

This filing has been submitted to or is exempt from filing in our domiciliary state of Connecticut.

Policy Form(s) and Endorsement(s) Submitted:

Form Title:	Dental PPO - Type A & B Visits and X-Rays
Lead Form No.:	GR-96134 3100 Ed. 05/09
Edition Date:	
Form Type:	Schedule
Form Title:	Dental PPO - Type B - Oral Surgery, Periodontics, Endodontics
Form No.:	GR-96134 3105 Ed. 05/09
Edition Date:	
Form Type:	Schedule
Form Title:	Dental PPO - Type B continued, Type C
Form No.:	GR-96134 3110 Ed. 05/09
Edition Date:	
Form Type:	Schedule
Form Title:	Dental PPO - Type C - Restorative, Prosthodontics
Form No.:	GR-96134 3115 Ed. 05/09
Edition Date:	
Form Type:	Schedule
Form Title:	Dental PPO - Type C continued
Form No.:	GR-96134 3120-1 Ed. 05/09
Edition Date:	
Form Type:	Schedule
Form Title:	Dental PPO - Type C continued

Form No.: GR-96134 3120-2 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Plan Features
Form No.: GR-96134 3135 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Plan Coinsurance
Form No.: GR-96134 3140 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Type A & B Visits and X-Rays
Form No.: GR-96134 3155 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Type B - Oral Surgery, Periodontics, Endodontics
Form No.: GR-96134 3160 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Type B Continued. Type C
Form No.: GR-96134 3165 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Type C - Restorative, Prosthodontics
Form No.: GR-96134 3170 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Type C continued
Form No.: GR-96134 3175-1 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Comprehensive Dental - Type C continued
Form No.: GR-96134 3175-2 Ed. 05/09
Edition Date:
Form Type: Schedule

Form Title: Exclusions That Apply To The Dental Plan
Form No.: GR-96134 3185 Ed. 05/09
Edition Date:
Form Type: Certificate

We trust with the enclosed information, you will be able to review our filing and grant an approval. If you have any questions, please contact the undersigned. Thank you in advance for your help and attention to this matter.

Product and Regulatory Affairs Manager

Phone: 860-279-1282
Fax: 860-952-2069
Email: CiesielskiJW@Aetna.com

ATTACHMENT A

GR-96134 3100 ED. 05/09	GR-96134 3105 ED. 05/09	GR-96134 3110 ED. 05/09	GR-96134 3115 ED. 05/09	GR-96134 3120-1 ED. 05/09
GR-96134 3120-2 ED. 05/09	GR-96134 3135 ED. 05/09	GR-96134 3140 ED. 05/09	GR-96134 3155 ED. 05/09	GR-96134 3160 ED. 05/09
GR-96134 3165 ED. 05/09	GR-96134 3170 ED. 05/09	GR-96134 3175-1 ED. 05/09	GR-96134 3175-2 ED. 05/09	GR-96134 3185 ED. 05/09

Explanation of Variability

GR-96134
3100
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits. Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

If a policyholder's plan only covers students, all references to children will be removed.

1. **Type A, B and C Expenses**

   The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**

   When included, the frequency limit for office visits for oral exams will vary within the range provided.

   When included, the frequency limit for prophylaxis (cleaning) will vary within the range provided.

   When included, the frequency and age limits for topical application of fluoride will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series x-rays, including bitewings, or panoramic film will vary within the ranges provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

Explanation of Variability

GR-96134
3100
Ed. 05/09

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

   X-Ray and Pathology
   When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
   When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

   When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

   When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

   When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
   When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

   When included, the frequency limits for full mouth debridement will vary within the range provided.

   When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
   When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
   When included, the time periods for restorative services will vary within the ranges provided.

   When included, the frequency limit and time period for occlusal guard will vary within the ranges provided.

8. **Type C Expenses – Visits and Exams**
   When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3105
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits. Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

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   When included, the frequency limit and the time period for the entire dental series x-rays, including bitewings, or panoramic film will vary within the ranges provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3105
Ed. 05/09

X-Ray and Pathology

When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**

When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**

When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**

When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**

When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the ranges provided.

8. **Type C Expenses – Visits and Exams**

When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3110
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits. Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

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Explanation of Variability

GR-96134
3110
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

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When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

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When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the ranges provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3115
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits. Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

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   When included, the frequency limit and the time period for the entire dental series x-rays, including bitewings, or panoramic film will vary within the ranges provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3115
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the ranges provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3120-1
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits. Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

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1. **Type A, B and C Expenses**
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   When included, the frequency and age limits for topical application of fluoride will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

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   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3120-1
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the ranges provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3120-2
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits. Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

If a policyholder's plan only covers students, all references to children will be removed.

1. **Type A, B and C Expenses**
   The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**
   When included, the frequency limit for office visits for oral exams will vary within the range provided.

   When included, the frequency limit for prophylaxis (cleaning) will vary within the range provided.

   When included, the frequency and age limits for topical application of fluoride will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series x-rays, including bitewings, or panoramic film will vary within the ranges provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3120-2
Ed. 05/09

X-Ray and Pathology

When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**

When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**

When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**

When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**

When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the ranges provided.

8. **Type C Expenses – Visits and Exams**

When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3135
Ed. 05/09

In the headings, either the term “comprehensive” or “limited” will be used, but not both.

The first sentence will be included when a policyholder’s plan includes a benefit maximum applicable to services and supplies related to a dental emergency.

1. **Policy Year Deductible** - When included, under a policyholder’s plan, the plan may include an individual deductible or both an individual and a family deductible. The individual and family deductible amounts will vary [within the ranges provided. The deductible may apply to all expenses or may be waived for certain expenses, (e.g., preventive). The expenses for which the deductible has been waived will be listed.

2. **Individual Deductible** - This item will be included when the deductible applies to a person who enrolls as a single person (e.g., no dependents). The deductible amounts will vary within the range shown.

3. **Family Deductible** - This item will be included when the deductible applies to members enrolled as a family. This is the only deductible that applies to all family members (e.g., no individual deductible). The deductible amount will vary within the range provided.

4. This paragraph will be included when the dental plan deductibles are integrated with deductibles applicable to other coverage under the plan. This paragraph will specify which coverage categories are included as part of the integrated deductible.

5. **Orthodontic Deductible** - The section on the orthodontic deductible will be included if the policyholder’s plan includes coverage for orthodontia, and the policyholder has also elected to include a separate deductible.

   The deductible may apply per policy year or per lifetime. The deductible amount will vary within the range provided. When the deductible applies on a lifetime basis, the end of the second sentence will refer to the covered person’s lifetime rather than the remainder of the policy year.

Explanation of Variability

GR-96134
3140
Ed. 05/09

In the headings, either the term "comprehensive" or "limited" will be used, but not both.

1. The first sentence will be included when plan coinsurance varies by expense type. The policyholder will have the option of electing the [following] coinsurance percentage levels that the plan will pay [and the percentages vary but will not be lower than what is shown]:
   - Type A Expenses will range from 100% to 70%;
   - Type B Expenses will range from 100% to 30%; and
   - Type C Expenses will range from 100% to 30%.
   - Orthodontic Treatment will range from 100% to 30%.

   The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C dental expenses.

   The reference to coverage for orthodontic treatment will be included when elected by a policyholder as part of their plan of benefits.

2. **Plan Coinsurance Limit** - When included under a policyholder's plan, the plan may include an individual limit or both an individual and a family limit. The dollar limits will vary within the ranges provided.

3. A policyholder may elect to exclude certain covered expenses from application toward the Coinsurance Limit. When applicable, the policyholder may include all or any of the covered expenses listed. If any applicable deductible and copay amounts accumulate toward the limit, the name of the limit will be changed, (e.g., "plan out-of-pocket). "Recognized" charge may be shown as "negotiated", "reasonable", "usual and customary" or words of similar meaning.

4. **Policy Year Maximum Benefit** - When included, the amount will vary within the range provided. The maximum may be combined with other health coverages under the policyholder's plan of benefits. When the plan is integrated with the policyholder's medical coverages, this item will name the medical coverages that are or are not integrated with the dental maximum. This paragraph will specify which coverage categories are included as part of the integrated Policy Year Maximum Benefit.

Explanation of Variability

GR-96134
3155
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits.

Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

If a policyholder's plan only covers students, all references to children will be removed.

1. **Type A, B and C Expenses**
   The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**
   When included, the frequency limit for office visits for oral exams will vary [within the range provided] [, but will not be less than what is shown].

   When included, the frequency limit for prophylaxis (cleanings) will vary within the range provided.

   When included, the frequency limits for topical application of fluoride will vary within the ranges provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series, including bitewings, or panoramic film will vary within the range provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3155
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the range provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3160
Ed. 05/09

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1. **Type A, B and C Expenses**
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   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**
   When included, the frequency limit for office visits for oral exams will vary within the range provided.

   When included, the frequency limit for prophylaxis (cleanings) will vary within the range provided.

   When included, the frequency limits for topical application of fluoride will vary within the ranges provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series, including bitewings, or panoramic film will vary within the range provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3160
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the range provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3165
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits.

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   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**
   When included, the frequency limit for office visits for oral exams will vary within the range provided.

   When included, the frequency limit for prophylaxis (cleanings) will vary within the range provided.

   When included, the frequency limits for topical application of fluoride will vary within the ranges provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series, including bitewings, or panoramic film will vary within the range provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3165
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the range provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3170
Ed. 05/09

This Dental Care Schedule will be used when the policyholder elects a coinsurance plan. The expenses listed in the Dental Care Schedule are variable. An expense may be added or omitted in accordance with a policyholder's schedule of benefits.

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If a policyholder's plan only covers students, all references to children will be removed.

1. **Type A, B and C Expenses**
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   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**
   When included, the frequency limit for office visits for oral exams will vary within the range provided.

   When included, the frequency limit for prophylaxis (cleanings) will vary within the range provided.

   When included, the frequency limits for topical application of fluoride will vary within the ranges provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series, including bitewings, or panoramic film will vary within the range provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3170
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the range provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3175-1
Ed. 05/09

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If a policyholder's plan only covers students, all references to children will be removed.

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   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**
   When included, the frequency limit for office visits for oral exams will vary within the range provided.

   When included, the frequency limit for prophylaxis (cleanings) will vary within the range provided.

   When included, the frequency limits for topical application of fluoride will vary within the ranges provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series, including bitewings, or panoramic film will vary within the range provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3175-1
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
When included, the frequency limits and time periods for root planning and scaling will vary within the ranges provided.

When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

5. **Type C Expenses – Periodontics**
When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

6. **Type C Expenses – Restoratives**
When included, the frequency limit and time period for restorative services will vary within the ranges provided.

7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the range provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3175-2
Ed. 05/09

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Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

If a policyholder's plan only covers students, all references to children will be removed.

1. **Type A, B and C Expenses**
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   In response to policyholder needs, a dental plan may cover Type A and Type B and Type C expenses, Type A and Type B expenses, only Type A expenses or only Type C expenses.

2. **Type A Expenses - Visits and X-Rays**
   When included, the frequency limit for office visits for oral exams will vary within the range provided.

   When included, the frequency limit for prophylaxis (cleanings) will vary within the range provided.

   When included, the frequency limits for topical application of fluoride will vary within the ranges provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit, time period and age limit for sealants will vary within the range provided. If coverage is applicable only to children, the reference to covered person will be changed to covered dependent.

   When included, the frequency limit for bitewing x-rays will vary within the range provided.

   When included, the frequency limit and the time period for the entire dental series, including bitewings, or panoramic film will vary within the range provided.

   When included, the frequency limit and the time period for vertical bitewing x-rays will vary within the ranges provided.

3. **Type B Expenses** - All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category (Type C Services).

Explanation of Variability

GR-96134
3175-2
Ed. 05/09

X-Ray and Pathology
When included, the frequency limit for periapical x-rays will vary within the range provided.

4. **Type B Expenses – Periodontics**
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When included, the frequency limits and time periods for gingivectomy will vary within the ranges provided.

When included, the frequency limits and time periods for gingival flap will vary within the ranges provided.

When included, the time period for periodontal maintenance will vary within the range provided.

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When included, the frequency limits and time periods for osseous surgery will vary within the ranges provided.

When included, the frequency limits for full mouth debridement will vary within the range provided.

When included, the frequency limits for bone grafts, first site in quadrant and each additional will vary within the ranges provided.

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7. **Type C Expenses – Prosthodontics**
When included, the time periods for restorative services will vary within the ranges provided.

When included, the frequency limit and time period for occlusal guard will vary within the range provided.

8. **Type C Expenses – Visits and Exams**
When included, the frequency limit for adjunctive pre-diagnostic tests will vary within the range provided.

Explanation of Variability

GR-96134
3185
Ed. 05/09

Exclusion That Apply To The Dental Plan

Throughout this section each bracketed exclusion may be omitted, or specific services or supplies mentioned within the exclusion may be omitted if the policyholder has elected to provide coverage, or the exclusion is already listed in the medical exclusions section

The exclusions on this page may be moved to the medical exclusions list when Aetna medical coverage is also purchased.

The product plan name applicable to the policyholder's coverage will print in the heading at the top of the page. Either the term "PPO", "comprehensive" or "limited" will be used, but they will not be combined.

Cosmetic Services: The bracketed phrase will print when certain items of the exclusion are covered under the dental plan.

Aetna™

Aetna Inc.
Attn: Accounts Payable, RW51
151 Farmington Avenue
Hartford, CT 06156-9132

Issuing Dept.: Accounts Payable
Vendor Number: 32364

No. 522850

62-20/311

04/30/2007

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STATE INS DEPT TRUST FUND
1200 WEST THIRD STREET
LITTLE ROCK, AR 72201-1904
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Alfred P. Tuck Jr.
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